DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

OFC 6/17/11

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445295	A. BUILDING _____ B. WING _____	C 05/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLSTON MANOR	3641 MEMORIAL BLVD KINGSPORT, TN 37664

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224 SS=G	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to ensure one resident (#3) with a fractured ankle was seen by the orthopedic physician of five residents reviewed. The facility's failure to ensure the resident was evaluated by an orthopedic physician resulted in more difficult surgical procedures and complications of infection and wound healing as a direct result of a delay in treatment for resident #3. The findings included: Resident #3 was admitted to the facility on January 7, 2006, with diagnoses including Seizure Disorder, Cerebral Vascular Disorder, Dementia, Chronic Hyponatremia, Osteoporosis, Osteoarthritis and Chronic Obstructive Pulmonary Disease. Medical record review of the Minimum Data Set dated October 18, 2010, revealed the resident had moderately impaired decision-making skills; required extensive assistance with bed mobility and assistance with transfers; was totally dependent on staff for dressing, toileting, hygiene and bathing; had no impairments of range of motion and had no pain.	F 224	**The filing of this Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact, exist. This Plan of Correction is filed as evidence of the facility to comply with the requirement of participation and continue to provide high quality resident care.** **F-224 Prohibit Mistreatment/Neglect/Misappropriation** 1. Resident #3 is being followed by an orthopedic surgeon. 2. A complete audit of all residents charts was completed by the Nurse Management Team on 05/04/2011 to ensure that consult/follow-up appointments have been scheduled appropriately. **Completion date: 5/4/11.** 3. Outside Facility Progress Notes/ER notes will be reviewed daily (Monday-Friday, weekend notes to be reviewed Monday) by the Director of Nursing/Assistant Director of Nursing to ensure compliance with all consults/follow-up appointments. Started on 5/3/11. 4. Administrator to audit Outside Facility Progress Notes/ER notes weekly x 4 weeks to ensure compliance. Quality Assurance Committee will review results during regularly scheduled meetings to evaluate findings and amend plan as necessary.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mark de Hueter — TITLE: Administrator — (X6) DATE: 5/13/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

MAY 18 2011

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F 224	Continued From page 1 Medical record review of a nurse's note dated November 8, 2010, at 10:00 a.m., revealed, "Resident found in floor in front of w/c (wheelchair) in floor. Seizure activity noted. Resident shaking & jerking uncontrollably. Unable to obtain accurate vital signs...NP (Nurse Practitioner) notified...transport to ER (Emergency Room) for eval (evaluation)..." Medical record review of a nurse's note dated November 8, 2010, revealed, "...will be transported back (to facility with no) new orders..." Continued medical record review revealed no documentation of the time the resident returned to the facility on November 8, 2010. Medical record review a of a nurse's note dated November 9, 2010, at 3:15 p.m., revealed, "X-ray done on (L) (left) foot...NP notified of results. Order to wrap...ace bandage and schedule appt (appointment) with (orthopedic physician) ASAP (as soon as possible)...Foot wrapped (with) ace bandage." Medical record review of an X-ray report dated November 9, 2010, revealed, "...Acute nondisplaced oblique (diagonal) fracture of distal fibula (outer bone of the leg)...moderate lateral soft tissue swelling...Mild Osteoporosis...Mild Osteoarthritis..." Medical record review of a nurses' notes dated November 10, 2010, revealed the resident complained of pain in the left ankle. The Nurse Practitioner was notified and ordered the resident sent back to the hospital. The resident was	F 224		

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F 224	Continued From page 2 transported back to the hospital emergency room on November 10, 2010, at 10:05 a.m. Review of a hospital x-ray report dated November 10, 2010, revealed, "...Mildly displaced..." fracture of the left ankle. Medical record review of a hospital physician's order dated November 10, 2010, revealed, "NWB LLE...Fx (fracture) boot...ECASA (Enteric coated aspirin) 325 mg (milligrams) po (by mouth) BID (twice daily) for DVT (Deep Vein Thrombosis) prophylaxis...f/u (follow up) next week for repeat x-rays in (orthopedic) office." Medical record review of a nurse's note dated November 10, 2010, (no time recorded) revealed the resident was returned to the facility with a "...walker boot on left lower extremity...NWB LLE (non-weight bearing left lower extremity)..." Medical record review of nurses' notes dated November 10, 2010-January 20, 2011, revealed no documentation the resident was seen by the orthopedic physician as ordered on November 10, 2010. Medical record review of a NP note dated January 20, 2011, revealed, "...F/U (follow up)...resident (with) nondisplaced fx of left distal fibula...was fitted (with) a boot in ER and has worn it since 11/9/10...missed appt (appointment) (with) orthopod (orthopedic physician). Will reassess...(L) foot is fully rotational (without) edema redness or pain..." Medical record review of a physician's order dated January 20, 2011, revealed, "...Xray 3	F 224		

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F 224	Continued From page 3 views of (L) ankle (f/u fx 11/10)..." Medical record review of an x-ray report dated January 20, 2011, revealed, "...Acute moderately displaced fracture of distal fibula and medial malleolus (lower end of the inner leg bone) with disruption of ankle mortise (joint)...Moderate lateral soft tissue swelling..." Medical record review of a nurse's note dated January 21, 2011, revealed the orthopedic physician was not able to see the resident in the physician's office, and the resident was transferred to the hospital on January 21, 2011. Review of a hospital physician's progress note dated January 21, 2011, revealed, "...fell 11/10/2010 injuring (L) ankle. Had nondisplced fx then-was splinted & (and) sent back to (nursing home)...did not f/u (with) orthopedic surgeon (after) injury. Sent here today (with) ankle dislocated..." Review of a hospital postoperative progress note by the orthopedic surgeon dated January 22, 2011, revealed, "Preoperative Diagnosis: Neglected trimalleolar fx dislocation (L) ankle...Procedure: Arthrodesis (surgical immobilization of a joint) (L) ankle..." Review of a hospital Discharge Summary dated January 24, 2011, revealed, "...The patient was admitted to the emergency room with chronically dislocated left ankle and non-united trimalleolar fracture...taken to operating room on 01/22/2011. At that time after mobilization...was felt that trying to proceed with an open reduction internal fixation bit more or less futile effort...for that reason, we	F 224		

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F 224	Continued From page 4 elected to proceed with arthrodesis. Postoperatively...course was relatively uneventful...did ooze a good bit from...ankle in the postoperative period...By postop (postoperative) day #2...medically stable and was felt...was ready for discharge back to (nursing home)...cast was changed prior to discharge...will follow up in the office in about a week and half..." Review of the orthopedic surgeon's office note dated February 3, 2011, revealed, "Almost 2 weeks s/p (after) arthrodesis of...left ankle for nonunited chronically dislocated trimalleolar ankle fracture...says...hasn't walked since...left hospital...still had drainage from both sides of the ankle from both wounds...nothing to suggest an infection...Replaced the short leg cast...will return in a week for suture removal..." Review of the orthopedic surgeon's office note dated February 10, 2011, revealed, "...removed the cast today...lateral wound has dehisced (burst open)...medial wound has stopped draining...removed sutures from the medial side...reasonable to go ahead and wash out the lateral wound and maybe wound vac (vacuum) it to try and avoid a chronic infection...was admitted to (hospital)..." Review of a hospital history and physical dated February 10, 2011, revealed, "...3 weeks status post arthrodesis of...left ankle for chronically dislocated nonunited trimalleolar left ankle fracture...was seen in the office and the lateral wound dehisced...Recommend debridement (removal of dead or damaged tissue) and irrigation in the operating room, application of the wound VAC..."	F 224		

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F 224	Continued From page 7 10, 2010, for an appointment with an orthopedic surgeon for follow up x-rays was not followed. Continued medical record review and interview with LPN #1 confirmed the resident was not evaluated by an orthopedic physician until January 21, 2011, (two and one-half months after the fracture occurred). Medical record review and interview in the conference room on May 2, 2011, at 3:15 p.m., with the Director of Nursing confirmed the facility failed to follow the physician's order dated November 10, 2010, for an orthopedic evaluation of the resident after the fractured ankle occurred. Telephone interview on May 3, 2011, at 9:00 a.m., with the orthopedic surgeon confirmed surgery to repair the displaced fracture of the left ankle was delayed because the facility failed to ensure the resident was evaluated by the orthopedic physician after the fracture occurred. Continued interview with the orthopedic surgeon confirmed the surgical procedure was more difficult resulting in more complications due to the delay in treatment of the fracture. Interview in the conference room on May 3, 2011, at 9:05 a.m., with the Medical Director confirmed the facility failed to ensure the resident had the follow-up appointment as ordered on November 10, 2010, resulting in a delay of treatment by the orthopedic surgeon.	F 224		
F 280 SS=D	C/O #27689 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged	F 280		

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F 280	Continued From page 8 incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to include interventions on the comprehensive care plan to address an indwelling urinary catheter and an intravenous line for one (#3) of five residents reviewed. The findings included: Resident #1 was admitted to the facility on June 22, 2010, with diagnoses including S/P (status post) CABG (Coronary Artery Bypass Graft), Hypertension, Chronic Kidney Disease, Chronic Gout, Indwelling Urinary Catheter, Peripherally Inserted Central Catheter (PICC), Coronary Artery Disease, Colostomy, Infectious	F 280	**F-280 Right to Participate Planning Care-Revise CP** 1. Resident #1 was discharged from the facility on 7/06/10. 2. Residents who have indwelling urinary catheters or PICC lines have the potential to be affected. Resident's care plans were audited by the Care Plan Office to ensure compliance. **Completion date is 05/12/11.** 3. Care Plan Coordinators and Case Manager were in-serviced by the Director of Nursing on ensuring that applicable interventions for resident who have indwelling urinary catheters or PICC lines are on the resident's care plan. 4. The Care Plan Team Leader will audit care plans of residents who have indwelling urinary catheters or PICC lines to ensure compliance weekly x 4 weeks to begin on the week of 5/16/11.	

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F 280	Continued From page 9 Enterococcal Endocarditis, Mildly Thickened Aortic Valve with trace Aortic Insufficiency, Bilateral Renal Cysts, Renal Atrophy, Dysphagia, GERD and Diabetes Mellitus. Medical record review of the initial nursing assessment dated June 22, 2010, revealed the resident had an indwelling urinary catheter and a PICC line for the administration of intravenous antibiotics. Medical record review of the care plan dated July 2, 2010, revealed no interventions related to the indwelling urinary catheter or the PICC line. Medical record review and interview on May 3, 2011, in the conference room, with the Registered Nurse/Minimum Data Set (MDS) Coordinator and the Licensed Practical Nurse (LPN) confirmed the care plan was not complete and did not include any interventions related to the indwelling urinary catheter or the PICC line. C/O #26249	F 280		